

Received Date: _____

By: _____

Approved Date: _____

By: _____

**Idaho Department of Health and Welfare
Region _____**

Application for Residential Habilitation Certificate

The undersigned hereby makes application for a certificate to operate a Residential Habilitation Agency, subject to the provisions of Idaho Code, and to the "Rules Governing Residential Habilitation Agencies," IDAPA 16.04.17. Medicaid providers are also subject to IDAPA 16.03.09 and IDAPA 16.03.10.

Type of Application (choose one):

___ **New provider application.**

___ **Change of Ownership. Administration or Lessee.**

Agency Name: _____

Business names of the agency as filed with the Secretary of State :

Agency Office

Name:

Street Address:

City:

State:

Zip:

Phone Number:

E-mail Address:

Would you like to receive information by e-mail? ☐ Yes ☐ No

Address(es) of any additional office location(2):

1.

2.

3.

For additional locations attach an additional page.

Note: Medicaid Providers will be required to submit claims separately from each location

Ownership:

Submit a copy of the corporation's articles of incorporation with designation as nonprofit or profit, public or private, and a copy of the bylaws. Check the entity that has legal responsibility for operation of the agency. Check only one in each column.

State/Local Government**Nonprofit****Profit****☐ State Government☐ Church Related☐ Individual☐ County Government☐ Nonprofit Corp.*☐ Partnership☐ City Government☐ Other☐ Corporation*☐ City-county Government☐ Hospital District

* If agency is a corporation, give **legal corporate name**:

**If "For Profit," list the names and addresses of those persons with ownership interests of five percent (5%) or more on separate sheets

Management Structure of the Agency (*if a governing board is utilized, please include names and contact numbers for each board member*):

Type(s) of Certificate:☐ Full☐ Temporary:

If temporary, describe duration and geographic area:

Optional Services To Be Delivered:

Services to Provide: (check all that apply)☐ Certified Family Home Agency affiliation☐ Residential Habilitation/Supported living☐ Adult Daycare (Refer to 16.03.10.705.12 and additional terms in Medicaid Provider agreement)

Geographic areas to be served (be specific to county and city):_____

Agency Documents: References to IDAPA rules that pertain to each requested document included. If a 3 number set is included the IDAPA 16.04.17 is used, if other IDAPA rules are referenced, the complete IDAPA rule number will be used.

Attach the following documents:

1. Medicaid Provider Enrollment Application
2. Proof of current liability insurance
3. Copy of W-9 submitted to IRS
4. Proof of Worker's Compensation insurance
5. Written description of the fiscal record system including a sample of program billing.
6. Organizational Chart
7. A Written Policy and Procedure to address each of the following:
 - **Scope of Services and Area Served.** Scope of services offered and geographic area served (300).
 - **Acceptance Standards.** Standards for acceptance of participants (300).
 - **Admission Procedures.** Agreement to serve the participant and the criteria that applies (302)
 - **Termination Procedures (302)**
 - **Records Standards.** Standards for clinical records maintained. (300, 16.03.10.704).
 - **Required Services.** Procedures that must be performed by each service. (300).
 - **Participant Safety.** Participant safety assessment procedures. (300). Safety measures to protect participants, staff and affiliated residential habilitation providers as mandated by state and federal rules (202)
 - **Emergency Care.** Emergency care measures and crisis and emergency planning. (300).
 - **Administrative Records.** Administrative records to be maintained. (300).
 - **Administrative Responsibilities:** Staff and affiliated residential habilitation provider training, evaluation and supervision (202).
 - **Quality Assurance:** Including Administrative oversight including quarterly and annual review and monitoring, participant satisfaction and overall agency evaluation. This should include checklists and monitoring tools. (202 and Additional Terms A-5)
 - **Personnel.** Personnel qualifications, responsibilities, and job description. (300, 301) This should include prohibitions listed in A-4 Additional Terms located in your Medicaid Provider agreement.
 - **Participant Rights.** Personal, civil, and human rights and dissemination of participant rights policies (300).
 - **Medication Standards.** Policy describing the program's system for handling participant medications which is in compliance with the IDAPA 23.01.01, "Rules of the Board of Nursing." (302)
 - **Participant Records.** Each agency must have and maintain a written policy outlining the required content of participant records, criteria for completeness, and methodology to be used to ensure current and accurate records. (400)
 - **Participant Rights.** Policy outlining the personal, civil, and human rights of all participants. The policy protects and promotes the rights of each participant.

- **Participant Finances:** Policy and Procedure to assure complete accounting of participants personal funds entrusted to the agency, or its employees, affiliated residential habilitation providers or contractors on behalf of the participants. (403).
 - **Treatment of Participants:** policies and procedures including definitions that prohibit mistreatment, neglect or abuse of the participant (405)
8. **Staff and Qualifications: (Refer to 16.04.17.202, 16.03.10.705)** Attach the following information to this application:
- Administrator: resume, job description, CHC, CPR/First Aid certification
 - Program Coordinator/QMRP: resume, CHC, degree, CPR/ First Aid certification
 - Direct care staff: job description, CHC,CPR/First Aid certification
 - Sample orientation and ongoing training as outlined in 16.03.10.705.01.c
10. **Sample Participant File:** including following information:
- Written description of the program records system
 - Sample admission agreement
 - Sample participant profile sheet
 - Sample participant rights form
 - Comprehensive assessment tool
 - Program implementation plan (sample program)
 - Monitoring record
11. **If your agency intends to provide Adult Day Care services:**
- Additional Terms signed
 - Sample Enrollment agreement (A-5)
12. Any other information requested by the Department for determining the agency's compliance with these rules or the agency's ability to provide the services for which certification is requested.

Signature

I certify that _____ Agency is in compliance with the "Rules governing Residential Habilitation Agencies", IDAPA 16.04.17 and all other applicable state and federal requirements;

I assure that _____ Agency is in compliance with pertinent state and federal requirements governing equal opportunity and nondiscrimination;

I further certify that the information submitted herein and attached to this application is true, complete, and correct to the best of my knowledge and belief.

Signature and Title, Authorized Representative

Date